



## CLIENT NEEDS ASSESSMENT/PARTICIPANT SERVICE PLAN

**Client Name:** \_\_\_\_\_

**Counselor:** \_\_\_\_\_

**Date of Assessment:** \_\_\_\_\_

Upon admission into the substance abuse treatment program, the assigned counselor should assess any additional needs the client may have. Of particular importance are those needs that may create barriers to the client finding employment or otherwise becoming a productive member of society. Please list and document appropriate follow-up. A partial list is below.

NEEDS List	YES	NO	Date Initiated	Date Completed
1. Non-Driver I.D.				
2. Social Security Card				
3. Birth Certificate				
4. Medical Card				
5. TB				
6. RPR				
6. Proof of Status				
7. Proof of Residence				
8. Proof of Care				
9. Proof of Income				
10. History & Physical exam				
11. Clothing				
12. Medical Assessment				
13. List of Medication				
14. Proof of Insurance				

# Here's To Life, Inc.

## Rw Care Ware Enrollment Form\*

<b>Last Name:</b>	<b>First Name:</b>	<b>MI: D</b>

<b>Service Date:</b>	<b>Date of Birth:</b>	<b>Client ID #:</b>	<b>County: Fulton</b>	<b>Zip Code:</b>

<p><b>Ethnicity: Check one</b></p> <p>Hispanic <input type="checkbox"/></p> <p>Non-Hispanic <input type="checkbox"/></p> <p><b>Gender: Check One</b></p> <p>Male <input type="checkbox"/></p> <p>Female <input type="checkbox"/></p> <p>Transgender <input type="checkbox"/></p>	<p><b>Race: (Check One)</b></p> <p>Black or African American <input type="checkbox"/></p> <p>White <input type="checkbox"/></p> <p>Asian <input type="checkbox"/></p> <p>American Indian or Alaska Native <input type="checkbox"/></p> <p>Native Hawaiian or Other Pacific Islander <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>
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**Services Received (Enter Number of Each Service Received):**

Screening	X	Support Group	X
Intake/Assessment	X	Breeze Card Trips	X
SACES	X	Meals	X
Treatment beds days		Case Tracking	X
MSM Stage Group	X	Referral	X
Linkage to care	X		

<p><b>Status: (Check One)</b></p> <p>HIV-positive, not AIDS <input type="checkbox"/></p> <p>HIV-positive, AIDS Status Unknown <input type="checkbox"/></p> <p>CDC-defined AIDS <input type="checkbox"/></p> <p>HIV negative <input type="checkbox"/></p> <p>HIV+ Date ___ / ___ / ___</p>	<p><b>Risk factors for HIV Infection: Check all that apply)</b></p> <p>Male who has sex with Male(s) <input type="checkbox"/></p> <p>Injecting Drug Use <input type="checkbox"/></p> <p>Heterosexual contact <input type="checkbox"/></p> <p>Hemophilia/coagulation disorder <input type="checkbox"/></p> <p>Perinatal Transmission <input type="checkbox"/></p> <p>Transfusion of Blood <input type="checkbox"/></p>
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<p><b>Primary Insurance: (Check One)</b></p> <p>Private Insurance <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p> <p>Medicaid <input type="checkbox"/></p> <p>Medicare <input type="checkbox"/></p> <p>Other Public Insurance <input type="checkbox"/></p> <p>None <input type="checkbox"/></p>	<p><b>Primary HIV Medical Care: (Check One)</b></p> <p>Publicly Funded Clinic/Health Department <input type="checkbox"/></p> <p>Private Practice <input type="checkbox"/></p> <p>Hospital Outpatient Center <input type="checkbox"/></p> <p>Emergency Room <input type="checkbox"/></p> <p>No Primary HIV Medical Care Source <input type="checkbox"/></p>
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<p><b>Housing Arrangements: (Check One)</b></p> <p>Permanently Housed <input type="checkbox"/></p> <p>Non-permanently Housed <input type="checkbox"/></p>	<p><b>Number in household:</b> _____</p> <p><b>Annual Household Income:</b> \$ _____</p>
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<input type="checkbox"/> Day Program
<input type="checkbox"/> HTL Housing Services

## Summary Of Clients Rights

At **Here's To Life, Inc.**, your rights are protected by the Rules and Regulations outlined in Chapter 290.4-9. Below is a combined and simplified summary of your rights and responsibilities. For any disputes or questions regarding these rights, please refer to the full Rules and Regulations.

**You Have the Right To:**

- Be treated with respect and dignity.
- Have your health and safety protected while receiving services on-site.
- Be informed of the names and professional status of the staff serving you.
- Consent to or refuse care and/or treatment as appropriate.
- Receive prompt and confidential services in the least restrictive environment.
- Access treatment without discrimination based on race, color, religion, national origin, age, sex, sexual orientation, gender identity, or disability.
- Participate in planning your treatment and receive education about it, including understanding the benefits, risks, and side effects of medications and alternatives.
- Be free from restraints or seclusion, mental, physical, sexual, or verbal abuse, and from neglect or exploitation.
- Pursue employment, education, and religious expression.
- Engage in social, religious, and community activities.
- Access free interpretation services as needed.
- Consult your own physician or attorney.
- Review your medical records with a clinician, unless deemed unhealthy.
- File grievances without fear of discrimination or retaliation.
- Receive a separate Notice of Privacy Practices regarding the confidentiality of your Protected Health Information.
- Request or refuse the release of your medical records in accordance with legal guidelines.

**You Have the Responsibility To:**

- Treat staff and other clients with dignity and respect.
- Seek medical attention promptly.
- Be honest about your medical history.
- Ask questions if you do not understand something.
- Follow health advice and strive to maintain a healthy lifestyle.
- Report significant changes in symptoms or lack of improvement.
- Respect "Here's To Life", Inc. policies, rules, and facility.
- Keep appointments or cancel within 24 hours in advance.
- Actively participate in maintaining eligibility for various benefits.
- Provide feedback on services and policies.
- Inform staff of any changes to your contact information as soon as they occur.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



# Proof Of Residency\*

I, \_\_\_\_\_, do acknowledge and affirm that I am currently residing in the county of Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb Coweta, Dekalb, Douglas, Fayette, Forsythe, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding or Walton.

I am presently receiving Day Program Services from **Here's to Life, Inc.**

\_\_\_\_\_  
Program Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
HTL Staff Signature

\_\_\_\_\_  
Date



<input type="checkbox"/> Day Program
<input type="checkbox"/> HTL Housing Services

## Zero Income Affidavit\*

Housing Opportunities for Persons with AIDS (HOPWA)

I, \_\_\_\_\_, have applied for emergency or rental assistance through the HUD Housing Opportunities for Persons with AIDS (HOPWA) program. As part of the program's regulations, verification of all household income is required.

**Income includes, but is not limited to:**

- Gross wages, salaries, overtime pay, commissions, fees, tips, and bonuses
- Net income from business operations or rental properties
- Interest, dividends, and other net income from real or personal property
- Periodic payments from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, and similar receipts
- Lump sum payments for delayed periodic payments (except as provided in 24 CFR 5.609(b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, workers' compensation, and severance pay
- Public assistance
- Alimony and child support payments, whether through the court system or not
- Regular pay, special pay, and allowances of a head of household or spouse who is a member of the Armed Forces
- Regular monetary gifts from family and friends

I hereby state that I have NO INCOME at this time. I have not received any income since \_\_\_\_\_. I do not expect to receive any income until \_\_\_\_\_.

I applied for \_\_\_\_\_ (other financial assistance) on \_\_\_\_\_ (date).

I understand that any misrepresentation or failure to disclose information on this form may disqualify me from the HOPWA program and could lead to termination of assistance.

**WARNING:** Providing false information to the government while applying for federal public benefits is unlawful under the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the information provided above is true and correct. I also understand that I must report any changes to my household composition or income in writing within ten (10) business days of such changes.

**Signature:** \_\_\_\_\_ **Witness (Staff):** \_\_\_\_\_

**Case Manager/Care Coordinator's Notes:**

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<input type="checkbox"/> Day Program
<input type="checkbox"/> HTL Housing Services

## Income Verification Affidavit\*

(for clients with income)

I, \_\_\_\_\_, do hereby swear that my current monthly income is as follows:

SOURCE OF SUPPORT MONTHLY (Please provide payroll statement, award letter, department of labor wage statement or other documents verifying income.)

Wages / Salary:	\$	
Disability:	\$	
Food Stamps:	\$	
Public Assistance:	\$	
Social Security:	\$	
Retirement / Pension:	\$	
Income Tax Return:	\$	
Family / Friends:	\$	
Stocks / Bonds:	\$	
Other:	\$	

I, \_\_\_\_\_, do hereby swear that neither I, nor my spouse, children nor anyone listed as a family member, are receiving any income other than what I have indicated above. I agree that if I receive any income during the course of my involvement with Here's to Life, Inc, I will immediately notify Here's To Life of the change in my financial status. I certify that the information I have provided above is true and accurate to the best of my knowledge. I understand any false information provided by me may result in prosecution for fraud in obtaining services.

\_\_\_\_\_ **By initialing here, I certify that I have no existing third-party or private health insurance providers, including but not limited to: Medicare, Medicaid, Veterans Assistance (VA), State Health Insurance, Peach State, or COBRA** Further, I understand that any misrepresentation of or failure to disclose information on this form may disqualify me from participation in the Ryan White program and may be grounds for termination of assistance.

**WARNING:** It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Act of 1986, 31 U.S.C. 3801-3812.

\_\_\_\_\_  
 (Printed Name and Signature) \_\_\_\_\_ Client \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness (Printed Name and Signature) \_\_\_\_\_ Date

## Appendix I

### Atlanta Eligible Metropolitan Area Ryan White Program and Ending the HIV Epidemic

## Global Client Consent\*

to Store and Share Information

Ryan White funding and Ending the HIV Epidemic (EHE) funding come from the federal government to help provide care and treatment for Persons Living with HIV (PLWH). Funds come to Fulton County through grants from the US Health Resources and Services Administration (HRSA) to serve a 20-county “Eligible Metropolitan Area” for Ryan White and a four-county area for Ending the HIV Epidemic. In order to get these grant funds Fulton County has to report data to HRSA’s HIV/AIDS Bureau. Fulton County uses computer programs called e2Fulton to report the data.

Once Fulton County gets the Ryan White or Ending the HIV Epidemic grant, it awards those funds to agencies in Metro Atlanta (Eligible Metropolitan Area) to provide services to people that qualify. These services include such things as healthcare, dental services, mental health services, transportation to get to and from appointments, food, and case management. When you get services from one of these agencies, they are required to share certain information about you with Fulton County so Fulton County can report the data to HRSA’s HIV/AIDS Bureau. The agencies use a program called e2Fulton to report data to Fulton County. e2Fulton is an online database used to collect information (data) about persons (clients) who get Ryan White or EHE services in Metro Atlanta.

Before you get Ryan White services, an agency must collect certain documents so they can see if you are eligible for services. To do this, they need:

1. Proof that you are living with HIV
2. Proof that you live in one of the 20 counties (Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, and Walton)
3. Proof that your income is less than or equal to 400% of the Federal Poverty Level
4. Proof of any insurance coverage you have.

Before you get Ending the HIV Epidemic services, an agency must collect certain documents so they can see if you are eligible for services. To do this, they need:

1. Proof that you are living with HIV
2. Proof of any insurance coverage you have.

Every agency that you get services from must have this information on file.

This agency participates in e2Fulton. By requesting and accepting services you are providing your consent (permission) to enter your personal information into e2Fulton. This information is used to determine your needs and provide supportive services to you and your household, and information is shared with other organizations that use this database, based on your signed consent.

### **What type of information may be shared with Fulton County in e2Fulton?**

We collect general and Protected Personal Health Information about you and record it in e2Fulton. Depending on your situation, this may include, but is not limited to:

- Your basic identifying information (including name, date of birth, sex, gender, race/ethnicity, HIV status, marital and family status, household relationships, contact information, veteran status, disability status, housing status).
- Your income information (sources and amounts of household income, employment information, work skills) and other resources, such as non-cash benefits.
- Type of health insurance, if any.
- Certain medical and support service information such as medical visits, lab results, prescribed medications.
- Your service needs and services received.
- Outcomes of services provided.
- Your emergency contact information.
- Other enrollment documents such as Client Rights and Responsibilities, Grievance Procedures, and agency-specific client consents.

### **Is your personal information safe?**

YES! e2Fulton is extremely secure and all information is completely confidential. E2Fulton is a customized part of a program called eCOMPAS (which stands for Electronic Comprehensive Outcomes Measurement Program for Accountability & Success). **eCOMPAS** and all features and modules developed on the **eCOMPAS** platform meet and exceed the highest standards of security and privacy and are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA). Your information in e2Fulton is secured by passwords and encrypted transmission technology (meaning data are scrambled and unrecognizable). In addition, each participating organization and system user must sign an agreement to maintain the security and confidentiality of the information. Your information is protected by the federal health information privacy standards. Sometimes, depending on the services provided by a participating organization, your information may also be protected by additional Federal and/or State regulations, which may require additional written consent prior to any disclosure.

### **Who can have access to your information?**

- All data in e2Fulton is accessible to the Fulton County Department for HIV Elimination.
- Ryan White and Ending the HIV Epidemic service provider organizations (agencies) can have access to your data. These organizations may include healthcare providers, case managers, patient navigators, social service providers, housing providers, and eligibility/enrollment staff, among others. Only staff that have a valid need to know will have access to your information.
- Information provided to HRSA is provided in the aggregate. What that means is that no individual information is provided, but all individual data are grouped together. For example, if you and 24 other people get medical care, we would tell HRSA that 25 people got medical care but not WHO the 25 people were. As another example, we would tell HRSA how many of the people served were male, how many were African American, etc., but not who those people are.
- You will, from time to time, be asked to complete a Client Satisfaction Survey so that we can look at how well our agencies are doing in serving you. The survey will be sent via text and/or email. You will be asked about such things as wait time, whether you were treated with respect, and

suggestions you have for making things better. This information will be used by the Fulton County Department for HIV Elimination and funded agencies. Your identifying information will not be shared with the funded agencies. Fulton County Department for HIV Elimination may reach out to you if your comments indicate a poor level of service or care.

- You may be asked to take a Needs Assessment Survey so that we can look at what needs you might have that are not being met. This information will be used by the Fulton County Department for HIV Elimination and the Metropolitan Atlanta HIV Health Services Planning Council to help us make decisions about what services to fund and how much funding should go to the service. Your identifying information will not be shared with the Planning Council.

### **How do you benefit from sharing your information? (What's in it for you?)**

In order to get Ryan White and Ending the HIV Epidemic (EHE) services you must be eligible for the program. To prove eligibility, you are required to provide certain documentation such as proof of HIV status, proof of income (or lack of income), information on where you live, and whether you have insurance that would cover some of the services. Every Ryan White or EHE agency that serves you must be able to show that they checked your eligibility. Instead of having to give your eligibility information to each and every agency that serves you, e2Fulton will allow your eligibility information to be seen by other Ryan White/EHE service providers. By sharing your information, you may be able to avoid being screened more than once, get faster and more personalized services, and minimize how many times you have to tell your “story”.

Also, if you need a referral to another Ryan White or EHE service provider, the referral can be sent electronically through e2Fulton along with any records that would be needed.

### **By signing below, you understand that:**

- Signing this consent form does not guarantee you services.
- You have the right to receive a copy of this consent form.
- This consent is valid for five (5) years from the date after the Protected Personal Information was created or updated. You will be given the opportunity to update your consent form as part of your recertification.
- You may cancel your consent at any time, but your cancellation must be done either in writing. You further understand that any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.
- Upon your request, we will provide you with:
  - A copy of the Client Revocation of Consent to Release Information;
  - A copy of your full records (apart from case notes) within five (5) business days of your request;
  - A current list of participating organizations that have access to your data.
- If you find inaccurate or incomplete Protected Personal Health Information in your records, you have the right to request a correction.
- Aggregate or statistical data that is released from e2Fulton will not disclose any of your Protected Personal Health Information.
- You have the right to file a grievance against any organization you feel has violated your confidentiality.
- If you need to be referred to another agency for services, certain information may need to be forwarded through e2Fulton to facilitate a referral. If you do not provide consent to share your

information, it may negatively affect participating providers from addressing your service needs in a coordinated fashion.

- You are not waiving (giving up) any rights protected under Federal and/or Georgia law.
- You understand that this information is necessary to appropriately coordinate care, document and evaluate services rendered, and assess clinical–medical outcomes which is required by the Health Resources and Services Administration, which funds the Ryan White Part A federal grant program and the Ending the HIV Epidemic Program.
- You understand that access to the information above is available to: HRSA; the Fulton County Department for HIV Elimination as the Ryan White Part A/ EHE Recipient as the custodian of all data stored in e2Fulton; subrecipients, other governments entities, certain consultants to the Fulton County Department for HIV Elimination who have completed the appropriate confidentiality agreements; and RDE Systems which provides the software and technical support for the eCOMPAS system.
- You understand that reproduction of your signed consent will be treated as authentic as original.
- You understand that your name, address, and other controlled identifiers are placed into e2Fulton, and that you have a right to request relevant health information that is tracked in the system.
- You hereby hold Fulton County Government harmless for disclosure and/or release of my **private** Health Information (**pursuant to Federal Health Insurance Portability and Accountability Act “HIPAA” regulations**) to any Ryan White/EHE contracted provider or the Health Resources and Services Administration (Funding Source) in connection with the Ryan White and EHE Program.

#### SIGNATURE AND ACKNOWLEDGEMENT

Your signature and initials below indicate that you have read (or been read) this client consent form and have received answers to your questions. Please indicate your sharing preference by choosing and initialing one of the options below:

#### SECTION A:

With this form, you are signing that you agree (provide consent) for agencies you get Ryan White or Ending the HIV Epidemic services from to share your information with Fulton County.

Please indicate your sharing preference by choosing and initialing either option 1 or option 2 below:

1. I consent to allow my information, and that of my minor children (if applicable, as listed below), to be shared with Fulton County via e2Fulton as described in this consent form.

**Initial here to give your consent \_\_\_\_\_.**

OR

2. I do not consent to allow my information to be shared via e2Fulton. **I understand that means that I cannot receive Ryan White or Ending the HIV Epidemic-funded services.**

**Initial here to deny your consent \_\_\_\_\_.**

**SECTION B:**

With this form, you are signing that you agree (provide consent) for agencies you get Ryan White/ Ending the HIV Epidemic services from to share your information with each other as indicated below. Your consent allows your record to be updated by any participating organization with which you interact without you being required to sign another consent form.

Please indicate your sharing preference by choosing and initialing one of the options below:

1. I consent (agree) to allow my information, and that of my minor children (if applicable, as listed below), to be shared among Ryan White or EHE agencies via e2Fulton as described in this consent form.

These agencies are:

AID Atlanta	Grady Health System – Ponce Center
AIDS Healthcare Foundation	Heather Ivy Society
Aniz, Inc.	Here’s to Life
Atlanta Legal Aid Society	HOPE Atlanta
Carl Bean Men’s Health and Wellness Center	Mercy Care
Clarke County Board of Health	NAESM
Cherokee County Board of Health	Open Hand Atlanta
Clayton County Board of Health	Positive Impact Health Centers
DeKalb County Board of Health	Someone Cares Atlanta
Emory University - Midtown	Southside Health Center
Fulton County Board of Health	THRIVE SS
Georgia Harm Reduction Coalition	To Our Shores

If there is an agency, or agencies, above that you do not wish to have access to your information please list here:


**Initial here to give your consent \_\_\_\_\_.**

OR

2. I do not consent (agree) to allow my information, and that of my minor children (if applicable, as listed below), to be shared among service providers via e2Fulton.

I understand that this choice means that I will need to provide my eligibility documentation separately to each Ryan White or EHE agency from which I get services.

I understand that this means that I will need to provide any documentation needed for referrals.

Initial here to **deny** your consent \_\_\_\_\_.

Client/Legal Guardian Full Legal Name (Please print): \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Electronic Signature is Allowed)

**Minor Children (if any):**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*For Agency Personnel Use Only:*

\_\_\_\_\_  
**Name of Organization**

\_\_\_\_\_  
**Name of Organization Staff**

\_\_\_\_\_  
**Signature of Organization Staff**  
(Electronic Signature is Allowed)

\_\_\_\_\_  
**Date**

Day Program HTL Housing Services

## Grievance Procedures

If you, the client, have a specific problem or complaint regarding the services received from Here's to Life, Inc., you have both the right and the responsibility to file a grievance. All grievances must be submitted in writing by you or your designee.

### What is a Grievance?

A grievance is a complaint about agency operations, social services, or care provided.

### How to Begin the Grievance Procedure

You may initiate the grievance process yourself or allow someone else to do so on your behalf.

The grievance must be submitted in writing to any of the following individuals:

- Any Counselor
- Any Staff Member
- Program Coordinator
- Executive Director

If you are unable to deliver your grievance in person, you can mail it to:

**Here's to Life, Inc.**  
Attention: Executive Director  
1115 Ralph David Abernathy Blvd SW  
Atlanta, Georgia 30310

### Grievance Procedure Steps

1. **Discuss the Complaint:** Begin by discussing your complaint with your Resident Assistant or any staff member in an attempt to resolve the issue informally.
2. **Submit a Grievance Form:** If the issue remains unresolved, complete a grievance/complaint form and submit it to the Resident Assistant. For verbal complaints, inform the Project Director or request your counselor to initiate the procedure.
3. **Response Timeline:**
  - i. For verbal complaints, expect a response within one business day.
  - ii. For written complaints, expect a response within five business days. If further investigation is needed, your counselor will provide periodic updates, unless the grievance is against them, in which case the Project Director will communicate with you.
4. **Discussion of the Issue:** The Project Director will reach out to discuss the grievance and explore potential resolutions.
5. **Appeal Process:** If you are not satisfied with the outcome, you may appeal the decision to the Executive Director for further resolution.



6. **Written Decision:** You will receive a written decision within 10 days, including the reasoning, and you can contact the agency for further discussion if needed.
7. **Follow-Up on Your Grievance**
  - i. After submitting your grievance, you can expect:
  - ii. Confidential and professional handling of your grievance.
  - iii. Fair processing through the agency's administration.
  - iv. Acknowledgment of receipt of your grievance in writing within seven (7) working days.
  - v. A response to your grievance within thirty (30) days.

**8. If You Are Not Satisfied**

- i. If you are not satisfied with how your grievance was handled, you may contact the Board of Directors of Here's to Life:

**Here's to Life, Inc.**  
Attention: Board President  
P.O. Box 361522  
Decatur, Georgia 30036

**Day Program**

While it is encouraged to use the agency grievance procedure, you are not required to do so. If you prefer, you may directly contact the Funding Agency of this project:

**Ryan White Program**  
Director  
137 Peachtree Street, S.W.  
Atlanta, Georgia 30303  
(404) 612-0789

By signing below, you acknowledge that these Grievance Procedures have been explained to you.

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Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

## Client / Visitor Grievance and/or Complaint Report

### **CONFIDENTIAL**

### **Grievance / Complaint Report**

All information that is provided will be held strictly confidential in the same manner as the client protections described in the U.S. Federal Confidentiality Regulations 42 CFR and the standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) as established by the Department of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to assist you at the maximum level of follow-up and outcome, we do request certain personal information below. However, if you do not want us to disclose your name for any reason, we will honor your wishes.

#### Information on Person Filing Report (optional)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Home Work Cell

E-mail: \_\_\_\_\_

*Date of Incident:* \_\_\_\_\_

*Time & Location:* \_\_\_\_\_

*Persons Involved:* \_\_\_\_\_

Please check the grievances listed below, if your grievance is not one of the ones listed please write it out in the section of Other.

- |  |   |
|--|---|
| <input type="checkbox"/> Threat of Termination / Discharge | <input type="checkbox"/> Procedures                       |
| <input type="checkbox"/> Dosage                            | <input type="checkbox"/> Pick-up                          |
| <input type="checkbox"/> Policies                          | <input type="checkbox"/> Schedule                         |
| <input type="checkbox"/> Unfair Cost of Treatment          | <input type="checkbox"/> Problems                         |
| <input type="checkbox"/> Medication Hours or Schedule      | <input type="checkbox"/> Accessibility to Staff           |
| <input type="checkbox"/> Punitive Staff                    | <input type="checkbox"/> Accessibility to Facility Safety |
| <input type="checkbox"/> Urine Testing                     | <input type="checkbox"/> Other: _____                     |

Although it is not mandatory that clients use the agency grievance procedure, it is encouraged. If a complaint would be more appropriately handled at the agency, that recommendation may be made to the client. But if the client refuses, the HTL Board of Directors is obliged to respond to the client.